In the Literature

SPECIALTY HOSPITALS: A PROBLEM OR A SYMPTOM?

Stuart Guterman

Health Affairs
January/February 2006
25(1):95–105

Full text is available at:
http://content.healthaffairs.org/cgi/content/full/25/1/95?ijkey=.oMTsWRDMc5BI&keytype=ref&siteid=healthaff

For more information about this study, contact:

Stuart Guterman
Senior Program Director
Program on Medicare's Future
The Commonwealth Fund
E-MAIL sxg@cmwf.org

or

Mary Mahon
Public Information Officer
The Commonwealth Fund
TEL 212-606-3853
E-MAIL mm@cmwf.org

This summary was prepared by Martha Hostetter and Deborah Lorber.

Commonwealth Fund Pub. #886
January 2006

In the Literature presents brief summaries of Commonwealth Fund–supported research recently published in professional journals.

THE COMMONWEALTH FUND
ONE EAST 75TH STREET
NEW YORK, NY 10021-2692
TEL 212.606.3800
FAX 212.606.3500
E-MAIL cmwf@cmwf.org
http://www.cmwf.org

Specialty hospitals are hardly a new phenomenon. There have long been children's hospitals, cancer hospitals, and other specialized centers for patient care. But the recent emergence of cardiac, orthopedic, and surgical hospitals around the country has generated some controversy—prompting Congress, in fact, to impose a moratorium on referrals of Medicare patients to these hospitals by physicians who own or invest in them. Originally part of the 2003 Medicare Modernization Act, the moratorium was extended in 2005 by the Centers for Medicare and Medicaid Services (CMS), which announced that it wanted to "carefully review our criteria for approving and starting to pay new specialty hospitals."

In "Specialty Hospitals: A Problem or a Symptom?" (*Health Affairs*, Jan./Feb. 2006), Stuart Guterman, senior program director of The Commonwealth Fund's Program on Medicare's Future, reviews the findings of two congressionally mandated reports on specialty hospitals and discusses their policy implications.

Concerns over Specialty Hospitals

Concerns about cardiac, orthopedic, and surgical hospitals stem from the issue of physician ownership. Some critics worry that physician–owners will be torn between considerations of clinical appropriateness and financial benefit when deciding among treatment options and settings to recommend to their patients. Critics also contend that because physicians who own specialty hospitals can, to some extent, control the flow of patients admitted, they may siphon off the least complex and most profitable cases. There is also strong incentive for these hospitals to avoid patients who are uninsured or underinsured.

For these reasons, community hospitals argue that specialty hospitals represent a financial threat to their livelihood. Community hospitals count on the profitable cases taken by specialty hospitals to subsidize their treatment of less-profitable cases and patients, as well as the other community services they provide.

Congressional Findings

Congress looked to two recent reports, by the Medicare Payment Advisory Commission (MedPAC) and CMS, to help address issues regarding the merits and flaws of specialty hospitals. Specifically, lawmakers sought to determine whether specialty hospitals are more efficient than community hospitals, whether they deliver care of comparable quality, whether they select less complex and more profitable cases, whether they undermine the financial viability of community hospitals, and whether they contribute to the community's benefit.

The MedPAC report, based on Medicare hospital cost reports and inpatient claims for 2002, concluded that specialty hospitals tend to treat fewer Medicaid patients than community hospitals in the same market, and generally treat more profitable patients. Such variation can occur because Medicare payment rates, which correspond to the clinical categories known as diagnosis-related groups (DRGs), may not reflect the relative costliness of cases across those categories

or because groups of cases within a given DRG may differ in complexity and costliness.

MedPAC found that specialty hospitals obtained most of their patients by capturing market share from community hospitals. This did not appear to have a substantial effect, however, on the financial performance of the community hospitals. MedPAC pointed out that specialty hospitals are relatively new and few in number, so their financial impact on community hospitals might increase over time.

The CMS report found that Medicare referrals to physician-owned specialty hospitals came primarily from the physician–owners (48% to 98% of all Medicare admissions). However, physician–owners did not admit their patients exclusively to their own hospitals.

In analyzing site visits to six market areas, CMS found that cardiac hospitals appear to have delivered care that was as good as or better than care at their competitor hospitals. There were insufficient numbers to assess quality of care at orthopedic or surgical hospitals, although levels of patient satisfaction were very high.

In most study sites, the Medicare cardiac patients treated in community hospitals were more severely ill than those treated in cardiac specialty hospitals. However, there was much variation in the average severity level among patients across cardiac hospitals and their competitors.

Policy Implications

Guterman argues that the congressional findings point to the need to refine the accuracy of Medicare payment rates. Following MedPAC's recommendations, CMS will be considering ways to adjust the current DRGs so that differences in complexity and costliness among patients are reflected in the payment rates. However, these proposals have been under consideration for more than a decade, indicating that improvements in payment accuracy may be considerably more difficult to implement than to identify.

Moreover, in the end, the issues raised by the controversy over specialty hospitals indicate much broader problems with the health care financing system. The low payments for most Medicaid patients and the lack of payments for uninsured patients means that privately insured patients are used to subsidize those shortfalls, creating strong incentives for community hospitals as well as specialty hospitals to attract well-paying patients and avoid others. "Above all," Guterman concludes, "the lack of explicit financing of the broader (and unprofitable) missions of health care facilities is a major failure, with implications far beyond the question of whether or not specialty hospitals should be allowed."

Facts and Figures

- Specialty hospitals tend to be small, with an average of 16 beds at orthopedic hospitals and 14 at surgical hospitals. Cardiac hospitals have an average of 52 beds.
- Specialty hospitals are not evenly distributed across the country: nearly 60 percent are located in just four states—Kansas, Oklahoma, South Dakota, and Texas.
- Among the hospitals in the CMS study, physicians had in aggregate a 34 percent ownership share in cardiac hospitals, although average share per physician was only 1 percent. Physicians had in aggregate an 80 percent ownership share in orthopedic and surgical hospitals; the average share per physician was 2 percent.